

[Clinic Name]
[Clinic Address]
[Phone Number]
[Email Address]

Date: [Date]

To Whom It May Concern,

This letter is to certify that **[Patient Full Name]** (Date of Birth: [DOB]) was under the medical care of [Clinic Name] following a diagnosis of COVID-19.

The patient has met the criteria established by the CDC and local health authorities to discontinue isolation. As of **[Clearance Date]**, the patient has completed the required isolation period and has been symptom-free (including being afebrile without the use of fever-reducing medications) for the required duration.

The patient is now considered medically cleared to return to:

- Work
- School / Childcare
- Physical activities and sports
- Normal public interactions

No further COVID-19 testing is required for the patient to return to their regular duties at this time, as individuals may continue to test positive for several weeks after they are no longer contagious.

If you have any questions regarding this medical release, please contact our office at [Phone Number].

Sincerely,

[Provider Signature]

[Provider Name, Credentials]
[License Number]
[Clinic Name]